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August 7, 2001

IN REPLY REFER TO:
FILE NO: 933 0008

Mr. Welton L. Irving, Chairman of the Board
WATTSHEALTH FOUNDATION, INC.
3405 West Imperial Highway
Inglewood, CA 90303

RE: NONROUTINE EXAMINATION OF WATTSHEALTH FOUNDATION, INC.

Dear Mr. Irving:

Enclosed is the Final Report of the nonroutine examination of the fiscal and administrative affairs of WATTSHealth Foundation, Inc. (the "Plan"), conducted by the Department of Managed Health Care ("Department") pursuant to Section 1382(a)[1] and Rule 1300.82.1(a) on November 20, 2000. The Department received the Plan's response on June 18, 2001 and on June 25, 2001 the Department began an on site examination of the corrective action plan submitted as part of the response.

In addition, under Attachment A of this report you will find the Department's findings from the review of the materials provided by the Plan in response to Exhibit A of the stipulated agreement between the Department and the Plan.

The Plan has not demonstrated a financially viable operation nor demonstrated the ability to comply with Sections 1375.1, 1376, 1371, 1371.35, Rules 1300.75.1, and 1300.76. As detailed in the report, the Plan has severe cash flow and liquidity problems and will not be able to comply with the tangible net worth requirements at all times.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et. seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

This report will be made public immediately.

If there are any questions regarding this letter, please call.

Sincerely,

JACK TONEY
Assistant Deputy Director, Office of Health Plan Oversight

cc: Dr. Clyde W. Oden, President and Chief Executive Officer, WATTSHealth Foundation, Inc.
Alma Graham, Vice President and General Counsel, WATTSHealth Foundation, Inc.
Jim Tucker, Chief Deputy Director
Herb Schultz, Deputy Director for External Affairs
Joan Cavanagh, Chief, Office of Enforcement
Mark Wright, Chief, Division of Financial Oversight
Brian Bartow, Chief, Division of Licensing
Robin Fried, Acting Chief, Division of Plan Surveys
DHS
CMS

DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF NONROUTINE EXAMINATION

FILE NO.: 933 0008

DATE OF FINAL REPORT: August 7, 2001

FINAL REPORT OF NONROUTINE EXAMINATION OF WATTSHEALTH FOUNDATION, INC.

This is a Final Report of the nonroutine examination of WATTSHealth Foundation, Inc. ("Plan"), conducted by the Department of Managed Health Care ("Department") pursuant to Section 1382 of the Knox-Keene Health Care Plan Act of 1975.

The exit conference was held on April 24, 2001 at which time the findings presented in this report were discussed with Plan representatives. The Plan representatives were Clyde Oden, President and Chief Executive Officer, Dave Petteway, Executive Vice President and Chief Operating Officer, Alma Graham, Esq., Vice President and General Counsel, Carlos Beharie, M.D., Executive Vice President and Chief Health Officer, R. Steven Shean, Chief Financial Officer, Jennifer Spalding, RN, Senior Vice President General Manager, and Michael A. Dowell, Esq., Miller and Holguin.

The Department issued a preliminary report to the Plan on May 3, 2001. The Department received the Plan's response on June 18, 2001. Concurrently the Plan invited the Department to conduct another financial examination of the Plan to assess the overall financial condition of the plan and to review, evaluate and make recommendations related to the ability of the corrective action plan to address and resolve the financial instability of the plan.

The examination of the corrective action plan was performed from June 25, 2001 through July 6, 2001. The Department engaged the services of Peterson Consulting to assist with the examination. As a result of the findings, the Plan and Department entered into a stipulation that required the Plan to take additional specific corrective actions.

This final report includes a description of the compliance efforts included in the Plan's June 18, 2001 response to the Preliminary Report, in accordance with Section 1382 (c).

I. PAYMENT OF CLAIMS – Repeat Deficiency

Section 1371 states that a health care service plan shall reimburse claims or any portion of any claim, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan in which case, the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan.

If an uncontested claim is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 10[1] percent per annum beginning with the first calendar day after the 30- or 45-working-day period.

Section 1371.35 applies to claims for emergency services. If an uncontested claim is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10[2] percent.

A nonroutine examination was performed on November 20, 2000. Follow-up procedures were performed in January 2001 and in April 2001. The examination and follow-up procedures disclosed that the Plan failed to pay claims in accordance with the timeframes required by Section 1371 and failed to pay interest in accordance with Sections 1371 and 1371.35.

Further, the Plan was routinely withholding claim payment checks for release because of insufficient cash funds. Interest was not accrued nor paid in accordance with the rates specified under these Sections. Also, interest was not paid to the release date of the claim payment, for claims paid beyond the 45 working days. In the six-month period ending March 27, 2001, the Plan withheld the following claim payment checks an average of 16 days:

Month of Check Issuance	Number of Checks Withheld	Dollar Amount of Checks Withheld
October 2000	851	$ 4,912,651
November 2000	965	3,964, 308
December 2000	950	4,527,029
January 2001	442	4,726,875
February 2001	579	7,309,890
March 2001	976	7,924,744

A similar deficiency was noted during the routine examination as of June 30, 1999, as stated in the Preliminary Report dated April 7, 2000. The Department found that the Plan held claim checks at

[1] Effective January 1, 2001, the interest rate is increased to 15 percent per annum.

various times in 1998 and 1999. As a result, the Plan filed an Undertaking dated May 25, 2000 with the Department stating, "The Plan will comply with Section 1371 of the Health and Safety Code."

The Plan was required to submit a detailed Corrective Action Plan (CAP) that addressed the concerns stated in this report. The CAP was required to include detailed projections that address all of the capital funding requirements that are necessary for the Plan to comply with the financial viability, TNE and claim payment requirements of Sections 1375.1, 1376, 1371, 1371.35 and Rules 1300.75.1 and 1300.76. The projections were also required to be accompanied by all applicable assumptions in sufficient detail and timelines for implementation.

The response stated that as of June 18, 2001, the Plan was current on claims payment and the financial projections submitted indicated that claims payments would remain current. However, based on the nonroutine examination started on June 25, 2001, it was noted that as of June 25, 2001 the plan was holding $9.5 million in claims in the system and was 2 months behind in entering claims into the system.

II. FINANCIAL VIABILITY

Section 1375.1 requires every licensed plan to demonstrate that it has a fiscally sound operation and adequate provision against the risk of insolvency. Rule 1300.75.1 requires that every plan demonstrate fiscal soundness and assumption of full financial risk through its history of operations, projections, maintenance of a positive cash flow and adequate working capital.

The Plan is in violation of this Section and Rule for the following reasons:

1. The Plan is not able to demonstrate that it can provide for the achievement of a positive cash flow, because it does not generate sufficient cash flow from operations to meet current and other liabilities as follows:

	As Reported to the Department					
Quarter Ending	3/31/00	6/30/00	9/30/00	12/31/00	3/31/01	6/30/01
Cash from Operations	$ 8,402,000	$(5,405,000)	$(2,954,000)	$5,778,000	$5,692,000	Not Available
Current Liabilities	53,838,000	44,000,000	40,569,000	58,196,000	54,070,000[3]	
Other Liabilities	6,271,000	7,168,000	5,532,000	6,378,000	4,595,000	
Excess Liabilities Over Cash From Operations	$(45,436,000)	$(56,573,000)	$(49,055,000)	$(58,796,000)	$(52,973,000)	

2. The Plan is not able to demonstrate that it can maintain a positive cash flow, because it does not maintain sufficient cash balances to meet current and other liabilities as follows:

[3] Does not include the year-end adjustment to IBNR made by the independent auditors.

	As Reported to the Department					
Ending	3/31/00	6/30/00	9/30/00	12/31/00	3/31/01	6/30/01
Cash & Short Term Investments	23,746,000	16,308,000	11,730,000	15,020,000	$18,897,000	$15,936,000
Current Liabilities	53,838,000	44,000,000	40,569,000	58,196,000	54,070,000	59,105,000[4]
Other Liabilities	6,271,000	7,168,000	5,532,000	6,378,000	4,595,000	4,126,000
Excess Liabilities Over Cash and Short Term Investments	$(36,363,000)	$(34,860,000)	$(34,371,000)	$(49,554,000)	$(39,767,000)	$(47,295,000)

3. The Plan is not able to demonstrate fiscal soundness and assumption of full financial risk through its history of operations, because it has reported net losses as follows:

Year End December 31, 2000 Audited Net Loss	$8,172,000
January 1, 2001 through June 30, 2001 (unaudited) Net Loss	$3,084,000[4]

4. The Plan is not able to demonstrate fiscal soundness because it routinely withheld the release of claim payments as described under Section I above, while making payments to its affiliates for the reimbursement of the Plan's administrative expenses and those of its affiliates. Cash transferred in the previous nine month period prior to May 31, 2001 were as follows:

Month ended	Cash Payment	Affiliate Paid
September 30, 2000	$2,359,577	WattsHealth Systems, Inc.
September 30, 2000	272,081	WattsHealth Property Management
October 31, 2000	1,553,439	WattsHealth Systems, Inc.
October 31, 2000	260,720	WattsHealth Property Management
November 30, 2000	1,874,158	WattsHealth Systems, Inc.
November 30, 2000	206,487	WattsHealth Property Management
December 31, 2000	2,524,326	WattsHealth Systems, Inc.
December 31, 2000	302,130	WattsHealth Property Management
January 31, 2001	1,873,140	WattsHealth Systems, Inc.
January 31, 2001	287,619	WattsHealth Property Management
February 28, 2001	1,917,905	WattsHealth Systems, Inc.
February 28, 2001	217,952	WattsHealth Property Management
March 31, 2001	1,713,720	WattsHealth Systems, Inc.
March 31, 2001	245,292	WattsHealth Property Management
April 30, 2001	2,154,098	WattsHealth Systems, Inc.
April 30, 2001	255,642	WattsHealth Property Management
May 31, 2001	1,765,005	WattsHealth Systems, Inc.
May 31, 2001	264,248	WattsHealth Property Management
TOTAL CASH TRANSFERS	$20,047,540	

The Plan has acknowledged that the banking arrangements between the Plan and its parent company, WattsHealth Systems, Inc. (WHS) permit automatic funding by the Plan's bank accounts to cover

[4] This amount is as reported to the Department by the Plan and does not include the Department's adjustment to IBNR.

disbursements to WHS. The Plan has been instructed to terminate this banking arrangement and to establish its own separate bank accounts that do not provide automatic funding to its affiliates.

On January 22, 2001, the Plan informed the Department that it had accepted the Department of Health Services' ("DHS") settlement offer of $5.98 million for the disputed Federally Qualified Health Centers ("FQHC") claims for the years 1992, 1994, 1995 and 1996. Although, the Plan is expecting these funds to relieve some of its short-term obligations, it is apparent that these funds are not sufficient to address all of the Plan's short-term and long-term obligations.

The Plan reported on its December 31, 2000 quarterly financial statements that it has 94,146 members, of which approximately 80% receive services under the Medicaid program and approximately 10% receive services under the Medicare program. The Plan receives prepaid premium revenue from the governmental agencies that fund these programs, however it is apparent that the Plan has not retained sufficient premium revenue to reserve for the related medical service obligations.

The Plan's responses included confirmation that the banking arrangement referred to above has been terminated and separate bank accounts have been established which do not provide automatic funding to affiliates.

The Plan was also required to revise the administrative services agreement to reflect the Plan's commitment to pay its medical services obligations (claims and capitation payments) on a timely basis, in accordance with Section 1371 and 1371.35. The agreement was to state that the Plan will not withhold any of these payments while issuing payments for other administrative expenses.

The Plan's response included an amended page to the administrative service agreement reflecting the claims and capitation payment obligations. The Plan's response stated the Plan will not withhold payment while addressing other administrative expenses.

In addition, the Plan was required to file detailed support and justification for the fees charged to the Plan.

The Plan's response included a budgetary schedule of the various administrative departments and other services provided through the administrative services agreement.

The affiliates of the Plan are dependent on the Plan for funding their operations. Though the Plan and affiliates have implemented cost cutting strategies, they do not appear adequate to sustain the long-term financial viability of the plan. The Plan has been underestimating its total medical liabilities, which results in underestimating future cash needs. For example, the independent auditors recorded an additional $9 million in incurred but not received (IBNR) medical liabilities at December 31, 2000. Then the IBNR was increased again by $10.7 million based on the Departments' calculations at May 31, 2001.

Ignoring the Department's IBNR adjustments, the Plan reports a working capital deficit of $20 million for both May and June 2001. Factoring in the Department's adjusted IBNR the working capital deficit grows to over $30 million.

As reported on the Plan's June 30, 2001 financial statement, reported cash, short-term investments, and premium receivables (if fully collectible) equal $23.8 million compared to total current liabilities of $59 million. During the on sight the plan had $9.5 million in claims waiting in the system to be released and a seven to eight week back log of claims to be entered into the claims system, which was estimated to be another $12.6 million for a total of $22.1 million in claims that requires adequate cash to be released.

Based on the Plan's current financial position, it does not have the working capital or liquidity needed to meet the daily operating needs of the Plan. This is also supported by the fact that the Plan's independent auditors had substantial doubt about the Plan's future and issued a "going concern" opinion.

III. TANGIBLE NET EQUITY

Section 1376 states that each plan shall have and maintain a tangible net equity ("TNE") equal to an amount that is calculated based upon requirements set forth in Rule 1300.76. Rule 1300.76(e) states that the required amount of TNE must be maintained at all times.

The Plan's monthly financial statements for the months ended September 30, 2000, through June 30, 2001 report the plan is deficient in the required amount of tangible net equity. The deficiency has grown from ($726,000) at September 30, 2000 to over a ($20 million) deficiency at June 30, 2001[5].

The Plan's response included projections that reported the Plan not achieving the required amount of tangible net equity until May 2002.[6]

IV. ADMINISTRATIVE CAPACITY

Section1367 (g) requires every plan to have the organizational and administrative capacity to provide services to subscribers and enrollees. Rule 1300.67.3 (a)(2) requires the plan organization to include staffing in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

The Plan is in violation of this section because it has not demonstrated the effective conduct of its business that results in the appropriate reserves of premium receipts to pay the related medical service obligations in accordance with the Sections and Rules cited above.

The Plan was required to submit a detailed Corrective Action Plan (CAP) that addressed the concerns stated in this report. The CAP was required to include detailed projections that address all of the capital funding requirements that are necessary for the Plan to comply with the financial viability,

[5] This amounts includes the Department's adjustment for IBNR
[6] This projected amount did not include the Department's adjusted IBNR.

TNE and claim payment requirements of Sections 1375.1, 1376, 1371, 1371.35 and Rules 1300.75.1 and 1300.76. Also required were the assumptions in sufficient detail and timelines for implementation.

As noted above, the Plan did submit a corrective action plan that included financial projections and related assumptions. However, based on the nonroutine examination of the corrective action plan, the Department has determined that the Plan will not resolve the liquidity and other financial problems of the Plan.

Attachment A

DEPARTMENT OF MANAGED HEALTH CARE

Response of the Department of Managed Health Care to WATTSHealth Foundation's Response to Action Plan

FILE NO.: 933 0008

August 7, 2001

The Department of Managed Health Care (the "Department") has reviewed the information submitted by WATTSHealth Foundation d.b.a. UHP Healthcare ("UHP") in accordance with the Action Plan, Exhibit A of the Stipulated Agreement Between the Department and UHP, executed on July 13, 2001. Based on the information filed, the Department finds that UHP's responses to the Action Plan do not establish fiscal soundness or adequate provision against the risk of insolvency as required by the Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), as amended, at California Health and Safety Code section 1340 *et seq*.[1]

The Department acknowledges that UHP has responded adequately to items 1, 5, 6, 7, 8, 10, 14, and 16 of the Action Plan. However, the proposals submitted by UHP in response to items 2, 3, 9, 12, and 13 do not demonstrate the necessary steps to achieve a fiscally sound operation and adequate provision against the risk of insolvency as required by section 1375.1(a)(1).[2] The Department's comments are set forth below.

Item 2 - Watts Health System shall put into writing a quantification and description of all services provided by Watts Health System to Licensee, by month for May and June 2001. Please include in detail what service, the amount of the service, and the calculation of charges to the Licensee. This exercise will enable the Licensee to make an informed decision regarding internalizing services previously provided by Watts Health System or affiliate companies, identify other potential vendors, and determine future purchase of services from Watts Health System or affiliates.

UHP submitted a quantification and description of services provided by WATTSHealth Systems, Inc. to UHP. The information submitted does not demonstrate that UHP can achieve a fiscally sound operation nor that UHP has adequate risk against insolvency as required by section 1375.1(a)(1).

Item 3 - Initiate a Cash Management program that aggressively manages expenses. No checks or other payment or transfer of funds may be issued to an individual payee in any single or accumulated transaction where the check payment or transfer amount exceeds $100,000 without prior written approval of the Department as stated in the Stipulated Agreement.

[1] Hereafter all references to "section" are to the specified sections in the California Health and Safety Code.

[2] UHP has not yet responded to items 11 and 15, as the deadlines for these items are August 15, 2001 and September 1, 2001 respectively. UHP's response for item 4 requires financial information for the months ended July 31, 2001 and August 31, 2001.

UHP merely submitted a Board of Directors resolution and an Executive Office memorandum instructing the affected UHP management and staff to comply with the directive in Item 3. The information submitted is non-responsive to Item 3 and does not demonstrate compliance with the fiscal soundness requirements of section 1375.1(a)(1).

Item 9 - Organizational management structure should be flattened to produce a more horizontal structure that would improve communications and timely decision making. Reduce the number of management staff, and realign compensation packages of management to be more incentive driven and aligned with company profitability. Additionally, the individual that "operates" the company on a day-to-day basis should have all key business areas reporting to that person. Provide new organizational plan for review by the Department by July 16, 2001. Included in that plan will be a discussion of salary reductions and changes in bonus structure to be based on Licensee profitability.

UHP merely submitted a Board of Directors resolution and an Executive Office memorandum instructing the affected UHP management and staff to comply with the directive in Item 9. The information submitted is non-responsive to Item 9 and fails to demonstrate compliance with the fiscal soundness requirements of section 1375.1(a)(1).

Item 12 - Change the current method of IBNR calculation to a more accepted method using claims lag reports. Complete by August 1, 2001.

UHP stated it commissioned its independent accountants, Ernst & Young, to conduct another assessment of UHP's claims liability for the month ended May 31, 2001 using the paid claims lag analysis method. UHP states that it will receive this report on August 8, 2001. The information submitted is non-responsive to Item 12 and does not comply with the fiscal soundness requirements of section 1375.1(a)(1).

Item 13 - Review all existing uses of cash (i.e. leased vehicles, etc.) and make a new determination of appropriate use of funds. Complete by July 25, 2001.

UHP submitted a report proposing appropriate uses of funds (including cash used for vehicle leasing), which includes an examination of the use of all UHP cash. The proposal fails to demonstrate compliance with the fiscal soundness and adequate risk against insolvency provisions required by section 1375.1(a)(1